State Health Benefit Plan
Prescription Drug Claim Form

INSTRUCTIONS

If you purchase prescriptions from a State Health Benefit Plan network pharmacy, your claim will usually be filed electronically. You will not need to file a paper claim form, except as explained below. Always present your State Health Benefit Plan I.D. card when purchasing prescriptions to receive the current member co-payment.

A paper claim form is required only for the following types of claims:

1. **Coordination of Benefits (COB)**
   When there is a coordination of benefits (COB) with another health plan, indicate whether the patient is covered under any other group health insurance plan. Attach a copy of the Explanation of Benefits (EOB) form from the other plan to this claim form. If the other plan does not issue EOBs, then attach prescription receipts from the pharmacy. Claims submitted for amounts that are equal to or less than your SHBP prescription co-payment will not be reimbursed. There is no coordination of benefits with another SHBP contract (dual coverage).
2. **When you use a Non-Participating Pharmacy**
   If you use a non-participating pharmacy, a paper claim form is required. Claims will be reimbursed based on the network-contracted rate minus the applicable SHBP prescription co-payment.

To avoid undue delay, please complete all the required information on this claim form.

HOW TO COMPLETE THIS FORM

Use a separate claim form for each family member.

1. Insured's identification number (copy from State Health Benefit Plan I.D. card).
2. Insured's name, address and telephone number.
3. Patient's name (person for whom the drug was prescribed).
4. Patient's date of birth, month/day/year.
5. Patient's sex: check male or female.
6. Patient's relationship to insured. If "other" please explain relationship.
7. Prescription information: Rx Number, Date Filled, New Rx or Refill, Metric Quantity, Days Supply, Prescriber Name or I.D. Number, NDC Number and Rx Price.
8. NOTE: Any claims for ostomy supplies should be submitted with your Employee Health Expense Report Form to the address listed on the form.
9. Name, Address, Phone Number and NABP number of pharmacy filling the prescription.
10. Attach prescription receipts to an 8 1/2" x 11" sheet of paper and then attach to this form or attach prescription printout from the pharmacy to this form.
11. Mail this claim form to:

    ESI-HEB Paper Claims
    PO Box 390863
    Bloomington, MN 55439

For SHBP claim and benefit information calls:
1-877-650-9342 or 1-800-842-5754 (TDD)

If you are a pharmacist with questions, call Express Scripts Pharmacy at 1-877-650-9340

EXPRESS SCRIPTS
Charting the Future of Pharmacy

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GEORGIA DEPARTMENT OF COMMUNITY HEALTH

EMPLOYEE MUST COMPLETE THIS SECTION

EMPLOYEE INFORMATION

EMPLOYEE SOCIAL SECURITY NUMBER

S T A T E G A

UMBRELLA GROUP NUMBER

EMPLOYEE LAST NAME FIRST NAME

STREET

CITY STATE ZIP

PATIENT INFORMATION

PATIENT'S NAME

SEX: ☐MALE ☐FEMALE

RELATIONSHIP TO EMPLOYEE: ☐SELF ☐SPOUSE ☐ELIGIBLE CHILD ☐OTHER (PLEASE EXPLAIN)

PATIENT'S DATE OF BIRTH (MM/DD/YY) / /

COORDINATION OF BENEFITS INFORMATION

Is the patient covered under any other group insurance plans that cover prescription drugs? ☐YES ☐NO

If yes, please provide the following information:

Is the other coverage ☐Other Medical/Drug ☐Medicare

Policyholder's Name _____ Insurance Company Name _____

Policy Number _____ Effective Date _____

Insurance Company Street Address _____

City _____ State _____ Zip _____

The undersigned certifies that the medication(s) described hereon was/were received by the undersigned for the party(ies) named below who is/are eligible for drug benefits, and that such medication(s) is/are not for an on the job injury. The undersigned authorizes release of all information to the plan administrator, underwriter, sponsor, policy holder, employer and their agents for use in connection with the benefit plan of the programs. Information may also be used for other reporting and analysis purposes without identification undersigned or the undersigned's family members. The undersigned further authorizes use of such person's social security number for identification purposes and further recognizes that reimbursement will be paid directly to the participant unless assignment of benefits is specifically authorized by the administrator.

X

SIGNATURE OF PATIENT, GUARDIAN OR LEGAL REPRESENTATIVE

( )

DAYTIME TELEPHONE

PHARMACIST MUST COMPLETE THIS SECTION

	Rx NUMBER	DATE FILLED	CHECK ONE (OPTIONAL)	METRIC QUANTITY	DAYS SUPPLY	PRESCRIBER NAME OR I.D.# (OPTIONAL)	Select DAW Code:	Rx PRICE
1.		MM/DD/YY	NEW Rx ☐0 REFILL Rx ☐1				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 Generic n/Stock ☐4 Brand = Generic ☐5 Override ☐6 Mandated by Law ☐7 Generic N/A ☐8 Other ☐9	$
	MEDICATION NAME, STRENGTH, DOSAGE FORM (OPTIONAL)		IS DRUG: (OPTIONAL) COMPOUND Rx ☐1 ALLERGY INJ. ☐2	NDC NUMBER				
2.		MM/DD/YY	NEW Rx ☐0 REFILL Rx ☐1				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 Generic n/Stock ☐4 Brand = Generic ☐5 Override ☐6 Mandated by Law ☐7 Generic N/A ☐8 Other ☐9	$
	MEDICATION NAME, STRENGTH, DOSAGE FORM (OPTIONAL)		IS DRUG: (OPTIONAL) COMPOUND Rx ☐1 ALLERGY INJ. ☐2	NDC NUMBER				
3.		MM/DD/YY	NEW Rx ☐0 REFILL Rx ☐1				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 Generic n/Stock ☐4 Brand = Generic ☐5 Override ☐6 Mandated by Law ☐7 Generic N/A ☐8 Other ☐9	$
	MEDICATION NAME, STRENGTH, DOSAGE FORM (OPTIONAL)		IS DRUG: (OPTIONAL) COMPOUND Rx ☐1 ALLERGY INJ. ☐2	NDC NUMBER				
4.		MM/DD/YY	NEW Rx ☐0 REFILL Rx ☐1				No DAW ☐0 MD DAW ☐1 Patient DAW ☐2 RPh DAW ☐3 Generic n/Stock ☐4 Brand = Generic ☐5 Override ☐6 Mandated by Law ☐7 Generic N/A ☐8 Other ☐9	$
	MEDICATION NAME, STRENGTH, DOSAGE FORM (OPTIONAL)		IS DRUG: (OPTIONAL) COMPOUND Rx ☐1 ALLERGY INJ. ☐2	NDC NUMBER				

PHARMACIST/DISPENSING PHYSICIAN MUST COMPLETE:

PHARMACY NAME / DISPENSING PHYSICIAN

PHARMACY NABP NUMBER

IF DISPENSED BY PHYSICIAN USE ALL 9 SPACES FOR TAX I.D. NUMBER

STREET ADDRESS

CITY STATE ZIP

PHONE # (OPTIONAL)

TOTAL PRICE $

THIS FORM MUST BE SIGNED: _____ SIGNATURE OF PHARMACIST/DISPENSING PHYSICIAN _____ DATE

NOTE: Payment for the above prescription(s) will be made directly to the EMPLOYEE unless assignment of benefits is specifically authorized by the administrator.

EMPLOYEE: PLEASE RETURN COMPLETED FORM TO THE ADDRESS SHOWN ON THE REVERSE SIDE

55250 07/07/04